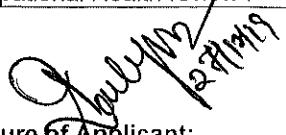
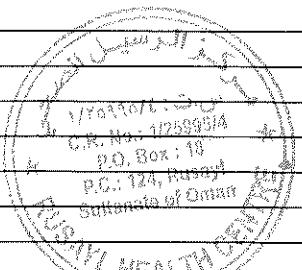


ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)

 RUSAYL HEALTH CENTRE <small>ISO 9001-2016 Certified Co.</small>		Surname/Forenames GAPAL RAMAL INGAM Nationality INDIAN, CIVIL-64731423, DOB: 02/02/1973		
Mobile No. 96714745	Home/Leave Address:	Company Number: 1405	Reference Indicator: TRUCKMAN	
Personal Details				
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)		
Home/Leave Address:		Relationship to employee <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter		
Reason for Examination (tick as appropriate)				
<input checked="" type="checkbox"/> Periodic Medical Examination		<input type="checkbox"/> Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>		
Employee only				
B Present Job and Location: ADMINISTRATOR, BAHJA		Next Job and Location: NA		
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>		
Previous Medical History: All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.				
Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe				
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	Description
1 Ear, nose, eye or throat problems		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2 Chest problems like asthma, bronchitis, other bad cough		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3 Heart abnormality, chest pains		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4 Abdominal pains, abnormal bowel motions		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
5 Urogenital problems (kidney disease, menstrual disorder)		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6 Skin trouble or allergies		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
7 Epileptic fits, dizzy spells or migraine		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
8 History of mental illness, depression anxiety		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
9 Diabetes, thyroid disease		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
10 Blood disorder e.g. anaemia, blood cancer e.g. leukaemia		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
11 Any history of accidents or fractures		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
12 Have you had any serious allergies		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
13 Do any dependants have a significant ongoing illness?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
14 Any family history of cancers		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you take any regular medicines, or have you taken in the past?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you smoke? If yes, what and how much each day?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol? If yes, what is your average weekly intake?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have you ever taken elicited/recreational drugs?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Are you doing regular sports or physical activities?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.				
 Date: 28-12-19 Signature of Applicant:				



FOR COMPLETION BY EXAMINING DOCTOR OR NURSE

Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)

PHYSICAL EXAMINATION

N	A	
✓		1. Eyes & Pupils
✓		2. E.N.T.
✓		3. Teeth & Mouth
✓		4. Lungs & Chest
✓		5. Cardiovascular System
✓		6. Abdo. Viscera
✓		7. Hernial Orifices
✓		8. Anus & Rectum
✓		9. Genito-urinary
✓		10. Extremities
✓		11. Musculo-skeletal
✓		12. Skin & Varicose Vns.
✓		13. C.N.S.

HEIGHT cm	WEIGHT kg	BMI	B.P. 105 78	PULSE 80/mins.	HEARING L R	VISION			
						DISTANT	NEAR	R	L
167	65	23.3				Uncorrected ① ①	Corrected / /	① ①	/ /

N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS	N	A
✓		1. Urinalysis		7. Audiogram
✓		2. Hb, Bloodcount, ESR		8. Lung Function
✓		3. LFT, RFT, RBS		9. Chest X-Ray
✓		4. Drug Screen	✓	10. ECG
✓		5. Lipids (40 years +)		11. CVS risk for 40 yrs. & above
✓		6. Sickle Cell test		12. HIV, Hepatitis screening

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

Advi
 • Regular exercise
 • Avoid high fat & sugar diet

ASSESSMENT AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

DR. HASAN MAHBUB KHAN BAYZID

Date: 28-12-19

Name (Block/Capitals): Dr. / Nurse



Signature:

REVIEW/CONSULTATION

RUSAYL HEALTH CENTRE
MOH LIC NO. 15691

Date:

Name (Block Capitals): Dr. / Nurse

Signature: